INDEX NUMBER

Vol. 69, No. 12 Established 1884 December 1952

ARCHIVES OF PEDIATRICS

A MONTHLY DEVOTED TO THE

DISEASES OF INFANTS AND CHILDREN

JOHN FITCH LANDON, M.D., Editor

LEADING ARTICLES IN THIS NUMBER

E. B. TREAT & CO., Inc., *Publishers*, 45 East 17th Street, NEW YORK, 3
Yearly Subscription $6.00 (Foreign $6.75); Single Copy, $1.00

Entered as second-class matter Feb. 5, 1892, at New York, N. Y., P. O., under the Act of March 3, 1879

No Fear, No Pain, No Memory

Now, there is a more humane approach to pediatric anesthesia. Eliminated is the unpleasant, too-familiar operating room "scene" with a frightened, fighting youngster. For with the rectal administration of PENTOTHAL Sodium, the child goes to sleep in his own bed *before* surgery—and wakes up there *after* surgery.

Rectal PENTOTHAL offers a relatively wide margin of safety. Controlled, individual dosages may be given to attain levels from preanesthetic sedation or hypnosis to basal anesthesia. When general anesthesia is desired, rectal PENTOTHAL reduces the dosage of inhalation agents. Emergence delirium and postanesthetic nausea are minimized. In many short, minor procedures, rectal PENTOTHAL may serve as the sole agent.

Abbott

SEND FOR NEW BOOK

"... **PENTOTHAL Sodium by Rectum.**" Thirty-six pages discussing the clinical value of PENTOTHAL by rectum for preanesthetic hypnosis and basal anesthesia—results from nearly 4000 cases. Write to Abbott Laboratories, North Chicago, Illinois.

PENTOTHAL® SODIUM

(Thiopental Sodium, Abbott)

by RECTUM

MULCIN

with its *natural orange flavor*

PUTS A *SMILE* IN

THE VITAMIN SPOON

The eager way that Mulcin is taken, even by finicky children, solves one of the most common problems in prophylactic vitamin supplementation.

Already accustomed to the refreshing flavor of orange juice, children and adolescents welcome Mulcin as a daily "treat." The yellow color of this vitamin emulsion is appetizing too. And there is no unpleasant aroma or after-taste to detract from acceptability.

Mulcin's smooth, non-sticky texture makes it easy to pour. For infants, it mixes readily with formula, fruit juice or water. Clear and light, Mulcin does not separate on standing or shaking. It's stable at room temperatures.

Superior in every way . . . Mulcin is truly an achievement in pharmaceutical elegance.

EACH TEASPOON SUPPLIES:

Vitamin A	3000 units
Vitamin D	1000 units
Thiamine	1.0 mg.
Riboflavin	1.2 mg.
Niacinamide	8.0 mg.
Ascorbic acid	50 mg.

MEAD'S

Available in 4 oz. and economical 1 pint bottles.

MEAD JOHNSON & CO. · EVANSVILLE 21, IND., U. S. A.

THE TRUTH ABOUT
FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays [1] emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three important respects:

a. Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;

b. Peel oil content was significantly *lower* in Minute Maid;

c. Bacterial counts were dramatically *lower* in Minute Maid.

Two chief reasons for Minute Maid's higher ascorbic acid content are advanced by qualified technical experts:

First, oranges vary widely in ascorbic acid content due to differences in varieties, rootstocks, and exposure to sunshine during ripening.[2] Thus, whole oranges, squeezed a few at a time in the home, provide a highly erratic source of Vitamin C. Yet because this vitamin is not well-stored in the body, optimum nutrition makes desirable a uniformly high intake. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients from orange to orange tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content during the time lag between producer and consumer.[3] Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained throughout the journey from tree to table. Controlled laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, previously shown to cause allergic response and poor tolerance, especially in infants,[4] is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher than Minute Maid.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. In the case of home-squeezed juice, high bacterial counts are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice where optimum year-around intake of natural Vitamin C is indicated.

REFERENCES

(1) *Rakieten, M. L., et al., Journal of the American Dietetic Association, October, 1951.*

(2) *U. S. Department of Agriculture Technical Bulletin No. 753, December, 1940.*

(3) *Roy, W. R., and Russell, H. E., Food Industries, Vol. 20, pp. 1764-1765 (1948).*

(4) *Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).*

MINUTE MAID CORPORATION, 488 Madison Ave., New York 22, N. Y.

Wallace R. Roy, Ph.D., Director of Research

TO CONTRIBUTORS AND CORRESPONDENTS OF

ARCHIVES OF PEDIATRICS

Subscription $6.00 a Year, in Advance **Foreign $6.75** **Single Copy, $1.00**

Editorial Communications address to JOHN F. LANDON, M.D., 120 East 75th Street, New York 21
Business Communications address to E. B. TREAT & Co., INC., 45 East 17th Street, New York 3

ORIGINAL ARTICLES, brief reports of rare and interesting cases, or new modes of treatment are solicited, but none will be considered for publication except with the distinct understanding that it is contributed exclusively to this journal. Manuscripts must be typewritten, double-spaced, and the original, not the carbon, copy submitted. The editor and publishers will not be responsible for views expressed.

ILLUSTRATIONS, as in the judgment of the editor are necessary, will be furnished free when satisfactory photographs or drawings are supplied. Photographs must be clear and distinct; drawings must be in India ink on white paper.

COPYRIGHT. — Original communications appearing in this journal are protected by copyright and can not be reproduced, either wholly or in part, without permission of the publishers.

REPRINTS of articles appearing among "Original Communications" may be ordered immediately upon receipt of galley proof by communicating direct with the publishers, E. B. Treat & Co., Inc., 45 East 17th Street, New York 3, who will supply their schedule of prices.

DISCONTINUANCES. — The publishers must be notified when a subscriber wishes his journal stopped and all arrearages must be paid. Without such notification it is assumed that a continuance is desired. Journals returned are not notice of discontinuance.

REMITTANCES should be made by check, draft, post office or express money order. If currency is sent, the letter should be registered. Stamps in amounts under one dollar are acceptable.

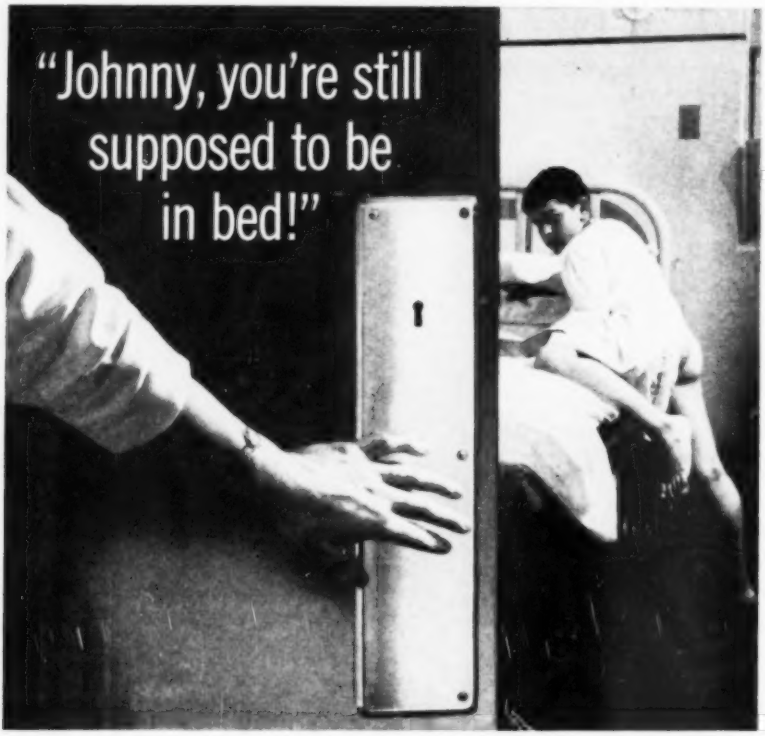
CHANGE OF ADDRESS NOTICE should give both the old and the new and state if change is permanent or temporary.

CONTENTS

ORIGINAL COMMUNICATIONS

(Continued on page 5)

INSTEAD OF UNPHYSIOLOGICAL "PHYSIOLOGICAL SALINE"*



℞ *Here's how new* POLYSAL® */CUTTER helps your patients:*

1. Polysal prevents and corrects hypopotassemia without danger of toxicity.[1]

2. Polysal corrects moderate acidosis without inducing alkalosis.[1]

3. Polysal replaces the electrolytes in extracellular fluid.[1]

4. Polysal induces copious secretion of urine and salt.[1]

Polysal, a single solution to build electrolyte balance, is recommended for electrolyte and fluid replacement in all medical, surgical and pediatric patients where saline or other electrolyte solutions would ordinarily be given. Write for literature and handy wallet-size mEq chart . . . Cutter Laboratories, Berkeley, California.

[1] Darrow, C. D., et al.: An Electrolyte Solution Approximating Plasma Concentrations with Increased Potassium for Routine Fluid and Electrolyte Replacement, J. A. M. A., March 8, 1952.

®Cutter Trade Mark

In distilled water—
250 cc. and 1000 cc.

CUTTER

***MAKE *New* POLYSAL YOUR ROUTINE PRESCRIPTION**

(Continued from page 3)

ITEMS

2 highly effective oral dosage forms

BICILLIN*

BENZETHACIL
DIBENZYLETHYLENEDIAMINE DIPENICILLIN G

- Extremely well tolerated
- Supplied ready for use
- Free from unpleasant penicillin taste
- Stable without refrigeration
- Dosage schedules need not be influenced by meal times

ORAL SUSPENSION

BICILLIN

. . . is unusually effective and palatable: ideal for use where flexibility of dosage is desired, as in pediatric practice.

Supplied: bottles of 2 fl. oz., containing 300,000 units per teaspoonful (5 cc.)

TABLETS

BICILLIN *L-A*

. . . provide *continuous* oral therapy on only 2 tablets a day, spaced 12 hours apart.

Supplied: bottles of 36 pink, grooved tablets of 200,000 units each

Wyeth®

*Trademark

the ***most widely used***

ethical specialty for

care** of the **infant's skin

DESITIN®

OINTMENT

the pioneer external

cod liver oil therapy

Decisive studies[1,2] substantiate over 25 years of daily clinical use regarding the ability of Desitin Ointment to . . . . . *protect, soothe, dry and accelerate healing in . . .*

- **diaper rash** • **exanthema**
- **non-specific dermatoses**
- **intertrigo** • **prickly heat**
- **chafing** • **irritation**

(due to urine, excrement, chemicals or friction)

Desitin Ointment is a non-irritant blend of high grade, crude Norwegian cod liver oil (with its unsaturated fatty acids and high potency vitamins A and D in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum, and lanolin. Does not liquefy at body temperature and is not decomposed or washed away by secretions, exudate, urine or excrements. Dressings easily applied and painlessly removed.

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars

write for **samples** *and literature*

DESITIN CHEMICAL COMPANY

70 Ship Street • Providence 2, R. I.

1. Heimer, C. B., Grayzel, H. G. and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

On every count.. superior vitamin supplements for infants

acceptability

The superior flavor of all three "Vi-Sols" assures patient acceptance. Mothers appreciate their convenience too.

dispersibility

With their clear, non-sticky texture, the "Vi-Sols" disperse instantly in fruit juice or water; mix readily with formula.

hypoallergenicity

Since all their vitamins are in synthetic form, the "Vi-Sols" are well tolerated even by allergic patients.

stability

Stable at room temperature, the "Vi-Sols" require no refrigeration. They may safely be autoclaved with the formula.

the versatile Vi-Sols®

3 water-soluble vitamin preparations for drop dosage

POLY-VI-SOL
TRI-VI-SOL
CE-VI-SOL

Available in 15 and 50 cc. bottles, with calibrated droppers

	Vitamin A	Vitamin D	Ascorbic Acid	Thiamine	Riboflavin	Niacinamide
POLY-VI-SOL Each 0.6 cc. supplies	5000 Units	1000 Units	50 mg.	1 mg.	0.8 mg.	5 mg.
TRI-VI-SOL Each 0.6 cc. supplies	5000 Units	1000 Units	50 mg.			
CE-VI-SOL Each 0.5 cc. supplies			50 mg.			

MEAD JOHNSON & COMPANY, MEAD'S **EVANSVILLE 21, IND., U.S.A.**

'POLYSPORIN'

brand

POLYMYXIN B—BACITRACIN OINTMENT

ANTI-GRAM-POSITIVE

BROAD SPECTRUM

ANTI-GRAM-NEGATIVE

Each gram of
'POLYSPORIN' OINTMENT contains:
AEROSPORIN ® brand Polymyxin B Sulfate 10,000 Units
BACITRACIN ..... 500 Units

BURROUGHS WELLCOME & CO. (U. S. A.) INC.
Tuckahoe 7, N. Y.

INDICATIONS

- infected wounds resulting from trauma or surgery
- infected burns
- infected skin graft
- abscesses and ulcers in any accessible location
- furuncles
- pyoderma
- ecthyma
- folliculitis
- infectious eczematoid dermatitis
- impetigo
- acne
- styes
- external ear infections
- eye infections such as:
  - conjunctivitis
  - blepharoconjunctivitis
  - scleritis
  - keratitis
  - dacryocystitis, etc.

SECONDARY INFECTIONS
superimposed on any dermatological condition

AVAILABLE IN
tubes of 15 Gm. with applicator tip
tubes of ⅛ oz. with ophthalmic tip

complete information will be sent on request

Catalysts FOR GROWTH...

Children of today are bigger than their fathers' generation. Much of this improvement in all-around growth and development can be attributed to the newer knowledge of nutrition and its application, particularly during the critical formative years.

Catalysts of nutrition are the essential vitamins so conveniently supplied for infants and children in

PLURAVIT® DROPS

POTENCY AND BALANCE

Pluravit Drops offer a well balanced formula.

A daily dose of 0.6 cc. provides:

VITAMIN A	5000 units
VITAMIN D_2	1000 units
VITAMIN B_1	1.0 mg.
VITAMIN B_2	0.4 mg.
VITAMIN B_6	1.0 mg.
VITAMIN C	50.0 mg.
NICOTINAMIDE	5.0 mg.
PANTOTHENIC ACID	2.0 mg.

EASILY ADMINISTERED WITHOUT WASTE

Pluravit Drops are quickly and uniformly dispersed throughout the infant's formula, fruit juice, milk, or whatever the youngster likes to drink. Pluravit Drops may also be administered in solid foods. Pluravit Drops do not adhere to the glass or bottle and do not float on the surface, so that nothing is lost, the full dose is assured, taste is minimized and absorption is encouraged.

Pluravit Drops are highly stable.

PLURAVIT DROPS... for infants ... growing children ... expectant mothers.
In bottles of 15 cc. with dropper.

Pluravit, trademark reg. U. S. & Canada

Winthrop-Stearns INC.
NEW YORK, N. Y. WINDSOR, ONT.

NEW *Pfizer Steraject Syringe*

holds 2 cartridge sizes

sterile, single-dose

Steraject*

disposable cartridges

the most complete line of single-dose antibiotic disposable cartridges

Steraject Penicillin G Procaine Crystalline In Aqueous Suspension (300,000 units)

Steraject Pencillin G Procaine Crystalline in Aqueous Suspension (1,000,000 units)

Steraject Combiotic* Aqueous Suspension (400,000 units Penicillin G Procaine Crystalline, 0.5 Gm. Dihydrostreptomycin)

2 cartridge sizes | *for only 1 syringe!*

Steraject Dihydrostreptomycin Sulfate Solution (1 gram)

Steraject Streptomycin Sulfate Solution (1 gram)

two cartridge sizes permit *full standard* antibiotic dosage

cartridges individually labeled

ready for immediate use

no reconstitution

for full details, ask your Pfizer Professional Service Representative

Steraject Cartridges:
each one supplied with sterile needle, foil-wrapped

introduced by **Pfizer** *world's largest producer of antibiotics*

*TRADEMARK, CHAS. PFIZER & CO., INC.

ANTIBIOTIC DIVISION • CHAS. PFIZER & CO., INC. • BROOKLYN 6, N. Y.

How Zest for Food leads to Zest for Life!

IT IS now clearly recognized that a baby's whole future development is profoundly influenced by his early experiences with food.

Happy mealtimes help a baby thrive emotionally as well as physically. You, yourself, have noticed how often a sunny disposition and sturdy vitality are found in the babies who eat with zestful appetite.

And as one of the many doctors who recommend Beech-Nut Foods, you will be glad to learn that there is a wider choice of appealing varieties than ever before—to *keep* mealtimes happy for your young patients.

Babies love them...

thrive on them!

A wide variety for you to recommend: Meat and Vegetable Soups, Vegetables, Fruits, Desserts—*Cooked* Cereal Food, *Strained* Oatmeal and *Cooked* Barley.

Beech-Nut

FOODS *for* BABIES

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Every Beech-Nut Baby Food has been accepted by the Council on Foods and Nutrition of the American Medical Association and so has every statement in *every* Beech-Nut Baby Food advertisement.

No spit-outs, puckered mouths, or protest

with

CRYSTAR

ONE-GRAIN ASPIRIN

TASTELESS ASPIRIN IN POWDER FORM FOR CHILDREN

TASTELESS!

DISSOLVES READILY IN CHILD'S FAVORITE LIQUID!

With CRYSTAR, tasteless aspirin in powdered form, you are assured accurate dosage. CRYSTAR, in individual tamper-proof packets, cannot be mistaken for candy. CRYSTAR dissolves readily in the child's favorite drink. That's why you will welcome CRYSTAR. Supplied in one-grain packets, boxes of 24, at pharmacies everywhere.

THE ARMOUR LABORATORIES CHICAGO 11, ILLINOIS

-world-wide dependability-

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

BLANKET COVERAGE

DAPTA®

multivitamin preparation for infants and children

Supplies generous amounts of the vitamins most frequently deficient.

You may depend on Dapta for stability, potency, palatability, miscibility, and ready absorption—even to the last drop. Dapta has no expiration date . . . refrigeration is unnecessary.

Supplied: Bottles of 15 and 30 cc. with graduated dropper.

FORMULA, EACH CC.:

Vitamin A	10,000 U.S.P. units
Vitamin D	2,000 U.S.P. units
Thiamine hydrochloride	3 mg.
Riboflavin	0.8 mg.
Niacinamide	15 mg.
Vitamin C	100 mg.

Wyeth®

ARCHIVES OF PEDIATRICS

VOL. 69 DECEMBER 1952 No. 12

JOHN FITCH LANDON, M.D., Editor

ENDOCARDIAL SCLEROSIS

REPORT OF CASE

MILTON H. HOLLANDER, LT. COLONEL, MEDICAL CORPS, U.S.A.*
BEDFORD H. BERREY, CAPTAIN, MEDICAL CORPS, A.U.S.**
AND
PAUL W. PALMER, CAPTAIN, MEDICAL CORPS, U.S.A.***
Denver, Colo.

Endocardial sclerosis is a congenital defect of the heart of unknown etiology associated with cardiac enlargement and resulting in sudden death during infancy. The subject has long been a controversial one, variously termed fetal endocarditis[1], fetal endomyocarditis[2] and endocardial fibroelastosis[3]. It is not discussed in Taussig's book on "Congenital Malformations of the Heart."

For many years this type of congenital heart abnormality was separated from the general group of congenital heart malformations because of the persistent belief that it had its origin in an inflammatory process. Early investigators felt that an inflammatory process involving the heart, occurring during the period of gestation following the formation of the major organ systems, was at fault[4]. However, the occurrence of fetal endocarditis has never been conclusively established[5].

Recent investigators favor a developmental origin for endocardial sclerosis. In 1941, Wearn[6] demonstrated, in clear anatomic detail, the components of the coronary circuit nourishing the muscle walls of the heart. The arteriosinusoidal, arterioluminal and thebe-

From the Pediatric and Pathology Services, Fitzsimons Army Hospital, Denver, Colo.
*Senior Resident, Pediatrics (now stationed at U. S. Army Hospital, Fort Hamilton, Brooklyn, New York); **Chief, Pediatrics; ***Resident, Pathology.

sian vessels branch off directly from the coronary arterioles to traverse the auricular and ventricular walls and empty into the chambers. In the same year, Gross[5] notes that the "myocardial lesions usually seen in so-called fetal endocarditis closely resemble healed bland infarcts." He suggested that such infarction might result from obliteration of the arterioluminal, arteriosinusoidal and thebesian vessels by fibrosis of the endocardium. He was unable to find evidence of inflammatory residua.

In 1946, Cosgrove and Kaump[7] again observed the resemblance of the myocardial lesions to infarcts, stressing the parallelism between the extent of myocardial and endocardial involvement. They noted the variability of gross pathologic changes, including thickening and opacity of the endocardium in the simpler forms, with distortion of the valves in the more severe cases.

The present concept of the pathogenesis of endocardial sclerosis is as follows[3, 5, 8, 9]: For some unknown reason, probably developmental, there occurs moderate to marked hyperplasia of the elastic tissue in the thickened endocardium. This thickened fibroelastic layer interferes with the emptying of the arterioluminal vessel into the atrial and ventricular chambers because of constriction of their orifices. With the establishment of obstruction to the flow of blood, dilatation of the intramyocardial capillaries develops, accompanied by partial stasis. Myocardial anoxia is reflected in dilatation, hypertrophy and ultimate failure of the ventricle.

This concept explains the myocardial degeneration and fibrosis. The heart muscle undergoes fatty infiltration, accompanied by muscle atrophy and degeneration, and finally fibrous infiltration and replacement.

CLINICAL FINDINGS

Infants with this condition generally follow a rather typical clinical course. They are usually normal at birth. The onset of signs or symptoms is sudden. Within a few months, the infants become irritable and develop feeding problems with refusal of part of their feedings or frequent vomiting, and consequently fail to gain weight normally. As the heart progressively enlarges, coughing and other symptoms of apparent respiratory infection become prominent. Attacks of dyspnea, with or without cyanosis, occur, after which the patient may temporarily improve only to relapse later. The patient may die during one of these attacks.

Roentgenograms of the chest reveal a greatly enlarged, globular heart with no specific contour, with normal lung vascularity. The total size of the heart may be so great that it extends forward causing prominence of the left anterior chest wall. Soft to loud, systolic murmurs, of a non-diagnostic quality may be heard over any part of the precordium. In a significant number of cases there may be no murmurs. The liver is usually enlarged though not remarkably; the spleen is occasionally palpable.

Electrocardiograms do not show any characteristic abnormalities.

PATHOLOGIC FEATURES

The heart is grossly enlarged and usually weighs 2½ to 4 times the normal. There is biventricular hypertrophy, predominantly left ventricular as a rule. The mural endocardium is markedly thickened, usually best developed over the anteroseptal surface of the left ventricle. This thickening occasionally occurs throughout the left ventricle and auricle, and is rarely best developed in the right ventricle. The papillary muscles are often incompletely separated from the ventricular wall, and chordae tendineae may enter the myocardium directly instead of being attached to the tip of a papillary muscle. Associated deformity of the mitral or aortic valves, characterized by thickening of the cusps with rolling of the free margin, has been found in the majority of cases.

Microscopic examination reveals replacement of the endocardium with a thick layer of collagenous tissue. In some cases, there is a great increase in elastic fibers. The underlying myocardial fibers are swollen and vacuolated and may show loss of nuclei and cross-striations. Tissue examination has failed to disclose Aschoff bodies of rheumatic carditis, "Bracht-Waechter" bodies of bacterial carditis, or the myocardial inclusions of toxoplasmosis. The effected valves are simply thickened but not otherwise abnormal microscopically.

DIFFERENTIAL DIAGNOSIS

At the present time it is not possible to make a definitive diagnosis of endocardial sclerosis during the lifetime of the patient. The disease may be confused with glycogen storage disease of the heart, which generally produces an identical clinical picture[10]. Other conditions to be considered include: anomalous origin of the left coronary artery from the pulmonary artery, rhabdomyoma, beri-

beri, Fiedler's acute isolated myocarditis, and idiopathic hypertrophy of the cardiac muscle.

PROGNOSIS

The prognosis is poor. After the clinical picture develops, the duration of life is rather short, often not more than ten days. Death,

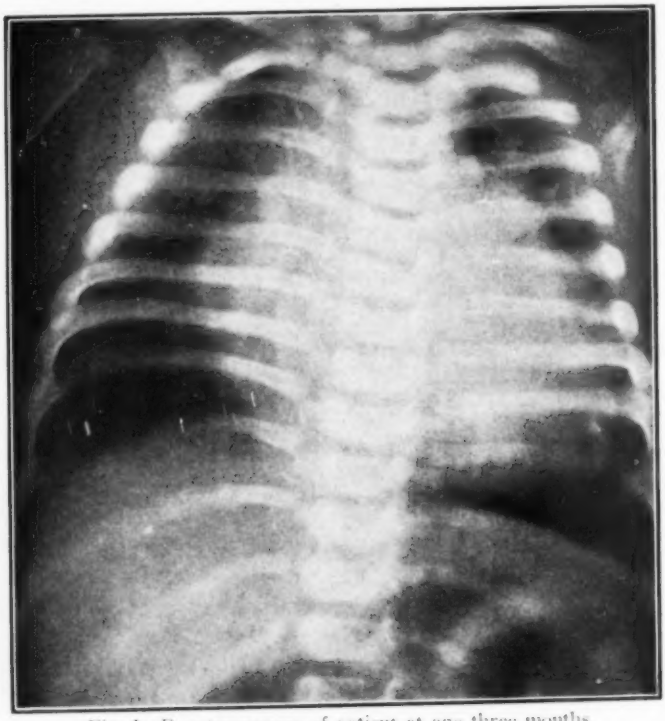


Fig. 1. Roentgenogram of patient at age three months.

as a rule, comes on prior to two years of age, the average being 4 to 6 months, and is frequently a sudden affair with cardiac failure the terminal event.

TREATMENT

Treatment is symptomatic. Digitalis offers temporary relief for cardiac failure, and oxygen will lessen the cyanosis, dyspnea and restlessness.

CASE REPORT

A 3-months-old white female was admitted to the Pediatrics Section, Fitzsimons Army Hospital, July 12, 1951, with chief complaints of dyspnea, feeding difficulties and failure to gain weight, all of two weeks' duration. She was the product of a full term, normal pregnancy, delivered by cesarean section because of cephalopelvic disproportion. Birth weight was eight pounds four ounces, and she was discharged home at seven days of age. She progressed normally until the onset of her present illness.

At 2½ months of age, for no apparent reason, she became irritable when fed and refused part of her feedings. The formula was changed without noticeable improvement. A few days later mild dyspnea and cyanosis developed. Physical examination revealed a markedly enlarged heart, with almost complete absence of breath sounds over the left chest. No cardiac murmurs were heard. The respiratory rate was 60 to 80 per minute. The liver was palpable four cm. below the right costal margin. A roentgenogram (Fig. 1) revealed a large, globular shaped heart almost completely filling the left chest and a portion of the right. Oxygen and digitalis were used with some clinical improvement, and the child was transferred to Fitzsimons Army Hospital.

COURSE IN HOSPITAL

On admission to this hospital, physical examination showed the child to be comfortable in oxygen and not cyanotic. She had a weak cry which persisted throughout her hospitalization. Obvious left anterior chest enlargement was present. There was tachycardia of 120 to 150 per minute, and a respiratory rate of 55 to 70 per minute. The heart was enlarged on percussion both to the left and right. There were no thrills, shocks or murmurs.

Digitalis was discontinued upon hospitalization and it was not necessary to re-digitalize her. She could be kept out of oxygen for 2 to 3 hours at a time; however, during these intervals she would become progressively more hyperpneic, up to about 100 respirations a minute. Return to higher oxygen concentrations produced a decrease to about 50 a minute. Occasionally a few fine râles were heard in the left base, felt to be secondary to compression of the overlying lung. Because of this finding and the very weak cry, an

associated vascular ring was considered but ruled out with a normal esophogram and tracheogram.

Following admission, a small left posterolateral mass became palpable and was thought to be the tip of the spleen. Since this might possibly have represented an enlarged kidney, a subcutane-

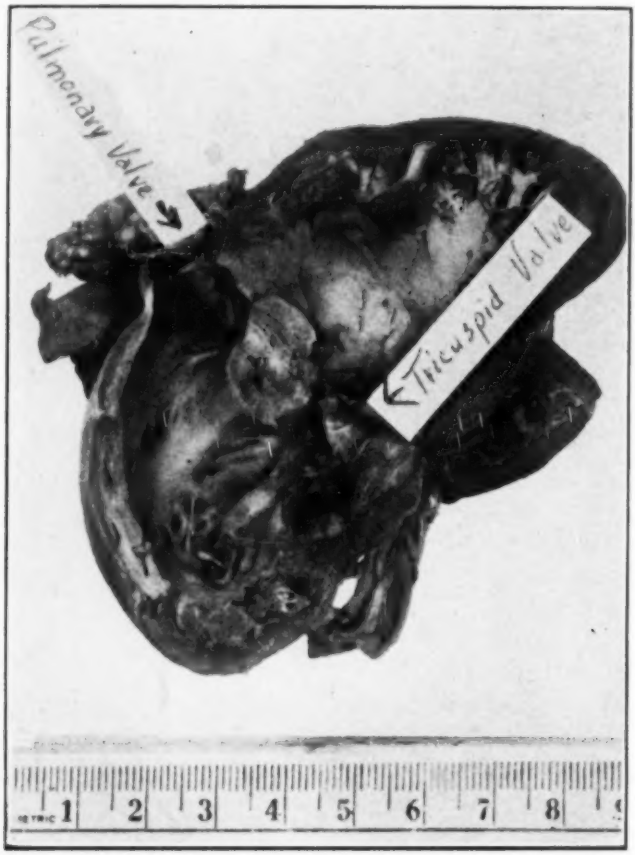


Fig. 2. Heart showing right ventricle with grayish-white, opaque endocardium and thickened ventricular wall.

ous pyelogram was done and interpreted as normal. Serial chest roentgenograms revealed no change in the size or contour of the heart. Complete blood counts and repeated urinalyses were normal. Serial electrocardiograms were non-contributary. A blood culture

remained sterile. The NPN was 40 and 43 on two occasions. Fasting blood sugar was 78 mg. per cent and the adrenalin tolerance test yielded a normal curve.

She was a relatively poor eater and failed to gain weight during her stay in the hospital. A few weeks after admission, a grade I systolic murmur could be heard over the lower precordium. This finding was inconstant, present some days and absent others. The general course was progressively downhill and she expired suddenly three months after admission at the age of 6½ months. An autopsy was performed.

POSTMORTEM EXAMINATION

Gross: Except for slight congestive hepatomegaly and splenomegaly, the only findings were in the heart (Fig. 2). The heart weighed 92 grams (normal, 31 grams). The epicardium was smooth, glistening and transparent. The myocardium was uniform reddish-brown with no focal softening or fibrosis. The left ventricular wall averaged 1.0 cm. in thickness and the right ventricular wall 0.8 cm. The endocardium was smooth, glistening, thickened, grayish-white and opaque. The thickening and opacity were decidedly more marked in the right ventricle, and the papillary muscles in the right ventricle were incompletely formed and blended with the ventricular wall. The chordae tendineae of the tricuspid valve were diffusely thickened and several entered the myocardium directly, showing no attachment to the tip of a papillary muscle.

Valves were normally formed and valve cusps were thin and delicate. The circumferential measurements of valve rings were: aortic, 2.4 cm.; pulmonic, 3.3 cm.; mitral, 4.4 cm.; tricuspid, 5.4 cm. The foramen ovale was anatomically patent, measuring 1.8 cm. in diameter. It appeared to be functionally closed. The coronary arteries showed no anomalies, arising from the aorta and branching in a normal manner. The ductus arteriosus was closed and major arterial trunks were normal.

Microscopic: Microscopic sections showed the endocardium to be replaced with a thick layer of fairly acellular collagenous tissue. Elastic stains demonstrated large numbers of elastic fibers arranged throughout the entire depth of the thickened endocardium (Fig. 3). The underlying myocardial fibers showed swelling and vacuolization of their cytoplasm. Many fibers revealed loss of striations and

nuclei. The epicardium and coronary arteries were not unusual. No inflammatory cells and no Aschoff or Bracht-Waechter bodies were present.

DISCUSSION

The duration of life following the onset of symptoms in endocardial sclerosis is generally short, about two weeks or less. Review

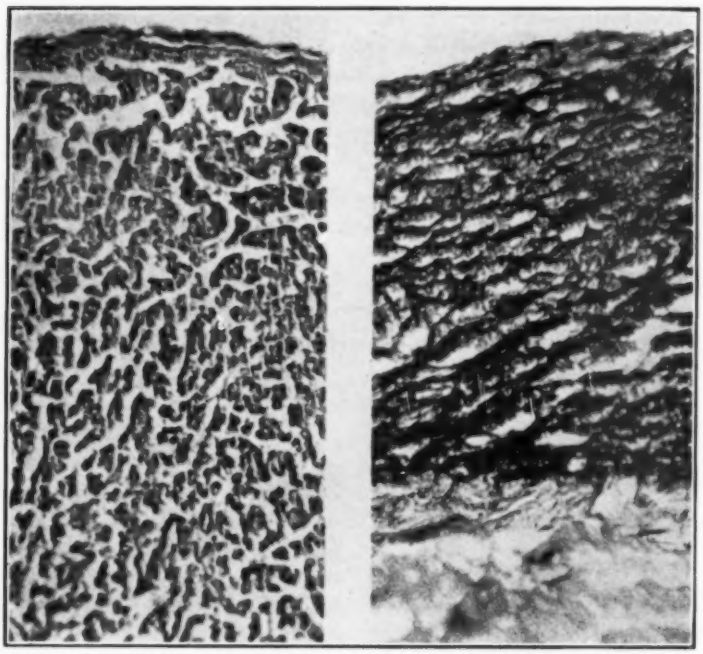


Fig. 3. Elastic tissue strain. *Left:* Normal heart in infant age six months, showing thin layer of endocardium at top of picture and normal myocardium below. *Right:* Case described showing markedly thickened endocardium with increased number of elastic fibers and hypertrophied, vacuolated myocardial fibers below. Both x 300.

of the literature[5, 9, 11, 12] reveals that cases with rapid demise consistently show a mural lesion involving the left ventricle. Our case showed greater involvement of the right ventricle than the left. It is quite probable that the longer duration of life with symptoms (4 months) can be explained on the basis of preponderant right ventricular pathology. This is consistent with the poorer prognosis

in cases of anomalous origin of the left coronary artery from the pulmonary artery as compared with the good prognosis when the right coronary artery arises from the pulmonary artery. These observations would indicate that venous blood appears to be adequate for the nutrition of the right ventricle but not for that of the left.

SUMMARY

A diagnosis of endocardial sclerosis was entertained in this case on admission to the hospital based on the history, physical examination (cardiomegaly without cardiac murmur, hyperpnea and hepatomegaly), roentgenogram (enlarged, globular shaped heart) and normal electrocardiograms. Due to the present state of our knowledge, it is not possible to positively establish the diagnosis ante mortem.

In a previously apparently healthy baby, the sudden onset of feeding difficulty, cyanosis and dyspnea, with or without cardiac murmurs, should suggest the possibility of endocardial sclerosis.

REFERENCES

1. Abraham, J.: Fetale Endokarditis. Zentralbl. f. Gynak., 61: 2698, 1937.
2. Farber, S. and Hubbard, J.: Fetal Endomyocarditis: Intrauterine Infection as a Cause of Congenital Anomalies. Am. J. M. Sc., 186: 706, 1933.
3. Weinberg, T. and Himelfarb, A. J.: Endocardial Fibroelastosis (so-called Fetal Endocarditis): Report of 2 Cases Occurring in Siblings. Bull. Johns Hopkins Hosp., 72: 299, 1943.
4. Brown, J. W.: Congenital Heart Disease (London) 1939.
5. Gross, P.: Concept of Fetal Endocarditis: General Review with Report of Illustrative Case. Arch. Path., 31: 322, 1941.
6. Wearn, J. T.: Observations on Morphology and Functions of some Components of Coronary Circuit. Bull. Johns Hopkins Hosp., 68: 353, 1941.
7. Cosgrove, G. E. and Kaump, D. H.: Endocardial Sclerosis in Infants and Children. Am. J. Clin. Path., 16: 322, 1946.
8. Craig, J. M.: Congenital Endocardial Sclerosis. J. Tech. Methods, 30: 15, 1949.
9. Edmonds, H. W. and Seelye, W. R.: Endocardial Sclerosis: Review of Changing Concepts with Report of Six Cases. Pediatrics, 7: 651, 1951.
10. Di Sant' Agnese, P. A.; Anderson, D. H. and Mason, H. H.: Glycogen Storage Disease of the Heart: Critical Review of the Literature. Pediatrics, 6: 607, 1950.
11. Prior, J. T. and Wyatt, T. C.: Endocardial Fibroelastosis: A Study of 8 Cases. Am. J. Path., 26: 969, 1950.
12. Collier, F. C. and Rosahn, P. D.: Endocardial Fibroelastosis: Report of Two Cases. Pediatrics, 7: 175, 1951.

TREATMENT OF DIAPER RASH*

ALFRED J. VIGNEC, M.D.

New York.

Diaper rash, both mild and severe, is a persistent problem which vexes many mothers. Traditionally, the treatment suggested is in cream or ointment form, and while these methods are useful and frequently satisfactory, there are several practical objections to them. Chief among these is the soiling and staining of clothing and bed linen, which is sometimes permanent. Also, the skin is frequently left sticky, and on subsequent urination and bowel movements a pasty, thick residue is left which requires firm and vigorous rubbing to remove. This results in trauma to the skin over the affected areas, which perpetuates and aggravates the condition.

If a satisfactory solution or liquid could be utilized in this very common skin irritation of children, many of these objections would be eliminated. Some attempts in this direction are being made, and one of the materials suggested is Bactine.† This preparation has been tested, and is in popular and safe use as a general germicide and antiseptic, as well as a fungicide and disinfectant.

The present study has been conducted in order to determine the usefulness of Bactine (used in full strength) as a treatment for diaper irritation and excoriation, and its possible usefulness in other minor skin conditions occurring in infants. We have also attempted to get some impression from the nurses and others using the material as to its acceptability on their part over a long period—effect on skin of hands, clothing, bed clothes, etc.

Material for the study was drawn from the New York Foundling Hospital, which has in residence about 250 infants and children under two years of age. The Foundling Hospital is a fruitful field, since most of the infants are abandoned or neglected, and on admission diaper excoriations often are quite severe.

The cases of diaper rash have been separated into two designa-

*From the Department of Pediatrics, New York Foundling Hospital.

†"Bactine" is the registered trademark of Miles Laboratories, Inc., for a clear, colorless liquid, faintly aromatic, containing di-isobutyl cresoxy ethoxy ethyli dimethyl benzyl ammonium chloride, polythylene glycol, mono-iso-octyl phenyl ether, propylene glycol, chlorthymol, alcohol 4%, camphor, methol, essential oils, and water q.s.

tions—mild and severe. Mild rashes are those in which only erythema or irritation of the buttocks was present. Severe cases are those in which thighs, abdomen and genitalia were affected, and all cases involving broken skin, pustules or excoriation.

Of the 272 cases, 138 were test cases treated with Bactine, and 134 were used as controls and were treated with a variety of other preparations (in ointment form) specifically intended for use in the handling of diaper rash and excoriation. Of this number, 255 were cases of diaper rash, and 17 suffered from other skin disorders. The babies suffering from conditions other than diaper rash were treated exclusively with Bactine.

RESULTS

	Good	Fair	Poor
Bactine			
Diaper rash—severe	37	13	10
Diaper rash—mild	32	19	10
	69	32	20
Controls			
Diaper rash—severe	34	19	10
Diaper rash—mild	44	17	10
	78	36	20

A classification of "good" constitutes improvement with complete clearing within seven days in all but severe cases in which excoriation was present. For these, "good" indicates improvement with complete recovery within ten days. A classification of "fair" constitutes improving with complete clearing within 14 days, while "poor" indicates no result within 14 days.

The difference in results with Bactine against other preparations is obviously not significant in cases of diaper rash. However, Bactine was as effective as any other standard preparation used, and had several additional advantages. It was convenient and pleasant to use, easy to apply, and safe in that at no time did it produce irritation or allergic reactions, either on patient or attendant. It received general acceptance from the personnel because it obviated removal of sticky dried crustings of feces and ointments mixed, and it was aromatic. It did not soil diapers or bed linen.

Three cases of eczema were treated with Bactine. The response

in one of these was fair; two were poor. In none of the three cases, however, was there exacerbation of the eczema. Eight cases of rash and excoriation of the neck: in four the response was good, in one fair, and in three poor. Two cases of furunculosis: one response good, one poor. One case of excoriated axilla: poor result. Three cases of generalized miliaria: response in all cases was good.

CONCLUSION

It may be concluded that Bactine is a safe, satisfactory and agreeable method of handling mild and severe diaper rashes and excoriations. It also seems to be useful for minor skin irritations, in particular miliaria.

145 *East 21st Street.*

TERRAMYCIN IN INFECTION IN CHILDREN. (British Medical Journal, London, 1: 419, Feb. 1952.) This report is based on the use of terramycin in 66 children: 35 with pneumonia, 10 with upper respiratory tract infections, 6 with tonsillitis, 3 with pyuria, and 12 with purulent conjunctivitis. Terramycin was available in capsules as the crystalline hydrochloride salt, and as a yellow crystalline powder that dissolves easily in a specially prepared cherry-mint-flavored liquid to make an elixir. A solution containing 25 mg. of terramycin as the crystalline hydrochloride dissolved in 5 cc. of distilled water with 62.5 mg. of sodium chloride and 25 mg. of sodium borate, was available for ophthalmic use. The elixir was given every six hours by mouth in doses of 50 mg. per pound (450 gm.) of body weight per day for seven days to each of 54 patients. The nurses preferred it to other antibiotics, because it was taken so readily by infants and children. Thirty-four of 35 patients with pneumonia responded rapidly, in most cases within 24 hours; one patient with a Friedländer's bacillus pneumonia died. Ten patients with upper respiratory tract infections, six with tonsillitis, and three with pyuria also showed a rapid and dramatic response. Eleven of 12 infants with purulent conjunctivitis responded rapidly. There were no toxic reactions, and it is stressed that terramycin, because of its wide spectrum of antibacterial activity and its easy administration, is particularly valuable in pediatric practice.—*Journal A.M.A.*

CHLORAMPHENICOL IN MEASLES

MARIO S. CIOFFARI, M.D.
Detroit, Mich.

The treatment of measles (rubeola) up to now has been very discouraging. If the child has had gamma globulin early enough in the incubation period, he is lucky. If not, cough medicine will make him a little more comfortable, antipyretics may reduce the height of the fever temporarily, and sulfa drugs or penicillin will help prevent complications.

In the average case, however, the little patient will "cough his head off," and run a high fever from 4-8 days in spite of treatment. Many parents, therefore, will not even ask the doctor to see the child during an epidemic, preferring to let nature take its course. Measles, as distinguished from "3-day measles," and other so-called measles, is a serious disease in itelf and may frequently have disabling or even fatal complications.[1]

Since the causative agent is a virus, and since the newer antibiotics have made a dent in this field, it was logical to consider chloramphenicol in the treatment of this childhood disease. The aim was to cure if possible, but at least to alleviate. This study was conducted during the 1952 epidemic before the shadow was cast over the drug because of a possible relation to aplastic anemia. This is a serious allegation and difficult to prove, but it has discouraged further widespread use. So far as we know, chloramphenicol is otherwise devoid of serious toxic reactions.

In the recent measles epidemic, the first case improved so rapidly under this treatment, by coincidence or otherwise, that it was decided to use it routinely and to check the results. The patients would have among the best of prophylactic medication, and could be benefited in the actual treatment. In this series, the drug was used in the form of Chloromycetin Palmitate.* It is thus well tolerated and very palatable. The dosage recommended is from 50-100 mg. per kg. per day in 4-6 divided doses; we used about 50 mg. per kg. per day.

The children under consideration were all private patients of middle-class circumstances. In this group the follow-up is difficult, since many will not return for a final check-up, when the child looks well. There were 44 patients who received chloramphenicol,

*Chloromycetin Palmitate, Parke, Davis and Company.
1. Mitchell-Nelson: Textbook of Pediatrics, 595, 597, 1950.

and of these, 30 returned for an evaluation of treatment. All were started in the Koplik's spots stage, that being the earliest reliable sign of measles, and usually the third day of illness; the drug was continued for 48 hours after the temperature returned to normal.

The Table 1 gives a graphic representation of the results. The estimate was based mainly on the duration of fever after the medicine was started, but also on symptomatic improvement:

TABLE 1. *Duration of Fever Under Treatment Related to Number of Patients.*

	1 day	2 days	3 days or longer
Male	5	6	5
Female	6	4	4
Totals	11	10	9
Percentage of total	37%	33%	30%

COMMENT

In this series there were no complications after chloramphenicol was started, and all were symptomatically improved within 24 hours, and an additional 30 per cent within 48 hours, irrespective of the period of measles. If the fever lasted more than 48 hours, the case was considered unimproved. An average expectation for normal temperature would be 48-72 hours after the rash begins to appear[1], along with a certain percentage of complications.

It is quite possible that 75-100 mg. per kg. per day would have given even better results, and it is a point to remember in the next epidemic. One of the children in the series had cervical adenitis before the Koplik's spots, and before starting treatment, and another had bilateral otitis media, under the same circumstances, while a third had chickenpox as a concomitant condition. They all cleared up rapidly under the chloramphenicol.

SUMMARY AND CONCLUSIONS

1. Chloramphenicol, in the form of Chloromycetin Palmitate was given to 44 children with measles (rubeola), ranging in age from 1-8 years; the amount was 50 mg. per kg. per day in 4-6 divided doses. Thirty of these children returned for check-up and evaluation of treatment.

2. In 11 children (37 per cent), the temperature dropped to normal within 24 hours of starting the medication; in 10 more (33 per cent), the temperature returned to normal within 48 hours, making a total of 67 per cent. In the last group, 9 patients (30 per cent), the fever lingered for 3 days or more under treatment.

3. There were no toxic symptoms from the drug itself, and no complications of measles developing after the drug was started.

4. This report suggests that chloramphenicol is of great value in the treatment of measles (rubeola). In view of recent developments, blood counts would be indicated for any extended treatment, until this drug is exonerated.

19363 *James Couzens Highway.*

FAMILIAL ERYTHEMA NODOSUM. (British Medical Journal, London, 1: 529, March 8, 1952). Fry defines erythema nodosum as a clinical entity consisting of a characteristic skin eruption, usually accompanied by a general constitutional disturbance. Although the etiology is not fully explained as yet, the general consensus is that it is a nonspecific reaction of a sensitive subject to various allergens. It is probable that erythema nodosum is associated oftenest with the primary tuberculous complex, but acute rheumatism, streptococcal infection, sarcoidosis, coccidioidomycosis, sulfonamide, hypersensitivity and a number of other conditions such as septicemia have also been observed with erythema nodosum. Fry describes a family with three children, aged 7, 5 and 3 years; the mother and the two older children had erythema nodosum lesions some weeks after bilateral open tuberculosis was diagnosed in the father. It seems certain that in the two children the development of a positive tuberculin skin reaction accompanying a primary tuberculous infection was associated with an eruption of erythema nodosum. This is also likely in the mother, but cannot be proved because there was no previous skin test. The author cites previous reports describing similar series of cases, and says that it seems likely that most of these multiple cases of erythema nodosum have been associated with a primary tuberculous infection.—*Journal A.M.A.*

MATERNAL PSYCHOLOGY

HOWARD L. EDER, M.D.
Santa Barbara, Calif.

Some discussion of the basic female psychology and how it differs from the normal male psychology is necessary before it is possible to understand the more peculiar phases of maternal psychology.

Shortly after their birth a noticeable difference in the male and female psychology is apparent. The normal girl shows an early interest in dolls and clothes. She will mother her pets or younger brothers and sisters and express the hope of having children of her own in the future. While the boy may play as an infant with dolls, he soon shows more interest in mechanical toys and is apt to be more boisterous and destructive by nature.

As the girl nears maturity she develops manifestations of a quieter nature and is shyer, more sensitive and emotional. Most girls show a change in disposition at some point during the menstrual cycle. Those girls who have a regular 28-day-cycle will usually notice a definite relationship of a personality change corresponding to the phase of the moon. They will also notice that this phase is repeated on the same day of the week. When this phase occurs on weekends or holidays, they very often are too irritable to enjoy themselves to the utmost.

Once a girl has reached maturity she shows no decided psychological change, even after she is married, until she has become pregnant. Then she is an entirely different person. After her first child is born she is no longer a girl; she is now a mature woman who must always keep the protection and welfare of her off-spring uppermost in her mind. She now has her "*real live doll.*" She continues to have interest in pretty clothes, not only for herself, but also for her child.

In the meantime what has happened to the boy? He has grown, finished his education, has a job, has married and fathered a child. He has not experienced pregnancy nor has he given birth to an offspring. He remains psychologically the same except for a realization of more responsibility. His wife can't understand why he is interested primarily in business, sports, hunting, fishing, gambling and stag parties. He can't understand why his wife is inter-

ested in her new home furnishings, new clothes, a silly hat or a pair of frail high heeled shoes with holes in the toes.

From birth the male and female psychology are so different that for one to understand the other is as impossible as Kipling's verse, "East is East and West is West and ne'er the twain shall meet".

A previous paper (ARCHIVES OF PEDIATRICS, March 1943) gave the maternal psychology during the postnatal period. We recognize a definite change in all mother animals which is partially a defense mechanism to protect the offspring. In the human mother four very obvious personality changes are evident for a period of about three months following the birth of each child. The mother is noticeably more irritable and sensitive, particularly to any criticism regarding her care of the new baby. She is also bothered by a temporary amnesia for recent events. She can't remember telephone numbers long enough to dial them or she may leave something in another room and be unable to find it. The highly emotional mother gets periods of weeping without provocation. She also has undue apprehension about the new baby as well as any other older children.

When an American Indian squaw gave birth to a papoose she went to live for three months in her parents' tepee while the old buck father left for a three months hunting expedition after which time they returned to live together in their own tepee. Smart people Indians!

The pediatrician should recognize another definite female psychology which is not present in the male. This is a metaphysical sixth sense between a mother and her offspring. I am sure we have all been called to see an ill child, for whom the mother has assumed the responsibility to prescribe her own "remedies" for several days in order to save a doctor's fee. When she finally has shared her reponsibility with the pediatrician her mental relief reflects in her child's condition, so much so that when the doctor arrives the child is playing or sound asleep for the first time in days. How many times have you arrived to see an ill child, and have the parents say that just a short time ago the child was much worse than it is now?

This metaphysical transmission of psychological stress is entirely a female trait. The mother can transmit her mental distress to either a son or a daughter until they reach maturity. After that

time they no longer are receptive but the daughter will affect her own offspring when she has children while the son will as a father be unable to do so.

The pediatrician must make every endeavor to give the mother peace of mind. The old saying goes that a father wearing mother's nightgown can't fool the baby when he is hungry. A mother who is mentally unhappy will not have a happy breast fed baby. Carnation milk has as a slogan "milk from contented cows". How much more important is contentment in a mother trying to nurse her child? I am sure that we all realize that an unhappy, crying, so-called "colicky" baby makes the mother more nervous and unhappy, therefore setting up a vicious circle. If there is any one factor in the presence of an adequate milk supply to satisfy the nursing child, it is an adequate supply of sugar in the diet of the mother, especially in between meals, thus keeping the blood sugar more evenly high which in turn insures a high content of sugar in the breast milk. The only food most apt to cause loose colicky stools in the mother's diet is grapes or anything from them, such as raisins, wine or cocktails. A small amount of alcoholic beverage, such as beer, ale or whisky, conserves blood sugar for the infant while the mother consumes the alcohol.

One other consideration to insure a happy infant is to find in which position the child prefers to sleep. Some infants will sleep soundly in any position; others prefer to be wrapped snugly in a blanket. Most infants try to get into the same position in which they spent nine months inside the uterus. Those who have no preference were probably floaters, rolling front and side and back. Those who are more contented on their backs were in an occiput posterior, while those who prefer to sleep on their faces were in an intrauterine occiput anterior position.

Just as mothers have this metaphysical power to influence their child mentally, they also seem to have a metaphysical intuition as to the seriousness of the illness. No matter how easily alarmed a mother normally is known by the pediatrician to be for minor illnesses, the doctor must always be alert for the extremely overanxious mother and use extra effort to avoid overlooking a more serious condition than the obvious physical findings would indicate. As an illustration, many years ago I was called early one morning to see a new patient. She was about four years of age,

lying quietly on a davenport before the fireplace in no apparent pain. Her temperature was 101° F. orally; physical examination was negative. No positive neurological evidence could be elicited. Having gotten out of a nice warm bed to see a strange child not seriously ill, I told the mother that I didn't think the child had much wrong with her; whereupon the mother informed me that she knew her own child well enough to realize when she was seriously ill. I had been unable to elicit any nuchal rigidity but when I asked the child to sit up she had a tendency to move with a fixed neck. I told the mother that I was putting the child into the hospital for further tests. A spinal tap revealed 100 to 200 cells; no clouding but positive smear for meningococci. This happened long before antibiotic therapy became available but with intrathecal meningococcic antiserum she made an uneventful recovery and was sent home after three days of treatment. I am sure that this child would have gone on for sometime before a stiff neck became evident had it not been for the mother's intuition and apprehension concerning the seriousness of her child's illness.

Another more recent case of a newborn that cried in pain such as a so-called baby with "colic". She had had several changes of formula, x-ray for possible thymus and hospital care for observation before I saw her. The home conditions were not good as the mother was having some marital trouble and was living with her parents with her other child. This mother kept insisting that something was seriously wrong with her infant. Many different milk mixtures were tried along with antispasmodics and sedatives. At times she was very happy, acting like a perfectly normal infant. The mother insisted that the child be taken to the hospital. Upon arrival nothing could be found abnormal and the history revealed no definite type of "spell" to account for the mother's anxiety. The local doctor told the mother she was unnecessarily upset which she resented and stated that she was not a hysterical mother. Later the same morning the child had repeated attacks of "spells" during which time she seemed unable to breathe and was returned to the hospital. She was at this time four months old. Her second morning in the hospital she had a definite generalized convulsion which developed cerebrally-caudally, first the eyes, cheeks, arms, intercostals, then lower extremities. The clonic spasms of the intercostals were so severe that the infant could not get air into her

lungs and she was given oxygen. The attack lasted approximately four minutes and subsided in reverse to onset.

An airencephalogram showed extensive porencephaly of the right with some on the left. The mother could always foresee the possibility of recurrng attacks 24 hours beforehand and would ask that her child be hospitalized. She called and requested that the child be hospitalized the day before its final attack. This mother had intuition concerning her baby from early infancy.

In summary: The female psychology is so different from the male that no man is able to comprehend it. The obvious differences are: 1. Postnatal maternal sensitivity. 2. The metaphysical maternal mental attitude, which is reflected in her preadolescent children. 3. Maternal premonition of serious illness in her children.

15 *East Arrellaga Street.*

AUREOMYCIN AND CHLORAMPHENICOL TREATMENT OF HERPES ZOSTER. (Ugeskrift for Laeger, Copenhagen, 113: 1537, Nov. 15, 1951). In a given period Schaffer and Svendson treated every other patient who had herpes zoster with aureomycin (500 mg. four times daily for four days) or chloramphenicol (from 2 to 4 gm. daily for from three to seven days). A total of 24 patients received antibiotic, and 22 control patients were given lactose tablets. No difference was noticeable between the treated group and the control group with regard to the duration of the skin affection or neuralgias.—*Journal A.M.A.*

ENURESIS. (Medical Journal of Australia, Sydney, 1: 357, March 15, 1952). The incidence of enuresis is considerably higher among children who have had early and rigid toilet training than among those allowed to achieve control naturally (34 of 38 as compared with 2 of 35). Severity and coercion may succeed in establishing a habit of continence, but subsequent anxiety and frustration may cause regression. Restoration or creation of a favorable psychological environment free from anxiety and with opportunities for normal development may reverse the process and reestablish control. Enuresis was noted in only two of 36 children who were subjected to severe frustration but who had not had coercive toilet training. Frustration alone, therefor, does not produce enuresis; it merely initiates it.—*Journal A.M.A.*

Archives of Pediatrics

A Monthly Journal Devoted to the

Diseases of Infants and Children

EDITED BY

JOHN FITCH LANDON, A.B., M.D.

Attending Pediatrist, Roosevelt Hospital and Women's Hospital; Visiting Physician, Willard Parker Hospital; Fellow New York Academy of Medicine, New York City.

VOLUME LXIX

JANUARY TO DECEMBER

1952

E. B. TREAT & CO., INC., Publishers

45 East Seventeenth Street

NEW YORK

LIST OF CONTRIBUTORS

ALDRICH, CHARLES J.

BERREY, BEDFORD H.
BERLER, ADOLPH H.
BLUM, SANFORD
BOS, JACOB
BOURNE, I. BLANCHE
BOYER, ROBERT
BROWN, EDWARD E.
BRUST, NORMAN M.

CARRIER, JOHN W.
CIOFFARI, MARIO S.
COHEN, ROBERT

EDER, HOWARD L.
EL GHOLMY, ADEL AZIM
EL SEBAI, BAYOUMI

FARKAS, ALADAR
FERGUSON, ANGELLA D.
FREEL, JOHN A.
FRIES, JOSEPH H.

GABR, M. K.
GANDLER, ALFRED L.
GEIGER, J. C.
GILLESPIE, JAMES B.
GINSBURG, VICTOR
GOLDSTEIN, LOUIS S.
GREENSPAN, WALDO
GUSS, LOUIS

HESS, J. H.
HOLLANDER, MILTON H.
HOLT, L. EMMETT

JAMES, THEODORE
JUNGEELUT, C. W.

KAPLAN, IRA J.
KNOX, A. W.
KOSS, LEOPOLD G.
KURTZKE, JOHN F.

LESSER, MATTHEW B.

MCCORMICK, W. J.
MORSE, JOHN LOVETT

NIEDELMAN, MEYER L.

ORLANSKY, GEORGE J.

PALMER, PAUL W.
PARK, GEORGE E.
PATTON, JOSEPH M.
PORTER, G. L.

RACHFORD, B. K.

SAKR, M. B.
SCOBEY, RALPH R.
SCOTT, ROLAND B.
SEIBERT, A.
STERNBERG, H. MELMUTH
SURE, BARNETT

THENEBE, C. L.
THODY, KATHLEEN

VIGNEC, ALFRED J.

WALDRON, ROBERT J.
WEBB, PATRICIA ANN
WEICHSEL, MANFRED

INDEX TO VOLUME LXIX

At your age!

If you are over 21 (or under 101), follow the example of our hero, Ed Parmalee, and face the life-saving facts about cancer as presented in our new film "Man Alive!". You'll learn that cancer is not unlike serious engine trouble—it usually gives you a warning:

(1) any sore that does not heal (2) a lump or thickening, in the breast or elsewhere (3) unusual bleeding or discharge (4) any change in a wart or mole (5) persistent indigestion or difficulty in swallowing (6) persistent hoarseness or cough (7) any change in normal bowel habits. Any one of these symptoms should mean a visit to your doctor. Most cancers are curable *if treated in time!*

You and Ed will also learn that your best "insurance" against cancer is a thorough health examination every year—twice a year if you are a man over 45 or a woman over 35.

For information on where you can see this film, call us or write to "Cancer" in care of your local Post Office.

American Cancer Society

"MAN ALIVE!" is the story of Ed Parmalee, whose fear weakens his judgment. He employs denial, sarcasm and anger to avoid having his car properly serviced and to avoid having *himself* checked for a symptom that may mean cancer. He finally learns how he can best guard himself and his family against death from cancer.